Population Council
South & East Asia—Regional office

Emergency Contraception
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Know Your Options

Medically Available Postcoital Options

Contents

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Reproductive Health Status in India

Unmet Need

- About 78 percent of conceptions each year are unplanned and 25 percent are definitely unwanted. According to the National Family Health Survey, 19.6 percent of married women want to delay their next pregnancy by at least 2 years.

Maternal Mortality

- Over 100,000 women die every year due to pregnancy and child birth related causes, and many more suffer from significant physical and psychological injuries.

Unsafe Abortion

- In the nineties, India had nearly twice as many abortions as had been estimated in the seventies. While a small fraction was due to higher incidence of sexual intercourse outside marriage, the overwhelming majority was due to unwanted and mistimed pregnancies within marriage.[3]

- Studies estimate that the number of abortions in India is now over 11 million a year, of which 6.7 million are induced and 4 million spontaneous. India also has a ratio of 10-11 illegal abortions for each legal abortion performed. All this results in 15,000 to 20,000 abortion related deaths annually and associated morbidity, almost all of which is preventable.[3]

- The high volume of spontaneous abortions, approximately 4 million, highlights the substantial and unnecessary drain on women's health, further affecting the already fragile condition of women's reproductive health status.[3]

- The available health infrastructure is already overburdened and cannot meet the cost of unplanned pregnancies, not to mention the physical and emotional costs borne by women.[4]

Emergency Contraception

What is Emergency Contraception (EC)?

Emergency Contraception:

- Is designed to prevent pregnancy after unprotected vaginal intercourse. It is also called post-coital contraception.

- Is provided in two ways:
  - ~ Emergency Hormonal Contraception – doses of birth control pills
  - ~ Insertion of an intrauterine device (IUD)

- Will only work if a woman is not already pregnant from a previous act of intercourse. It prevents pregnancy by preventing ovulation, fertilisation, or implantation. It will **not** cause an abortion.

- Is a recognised standard of care that is expected to be made available by medical professionals, and other women's health and family planning centres.

A History of Emergency Hormonal Contraception

Emergency Contraceptive Pills (ECPs) around the world

For several decades, ECPs have been prescribed to prevent pregnancy after unprotected intercourse, in cases of unanticipated sexual activity, contraceptive failure, or sexual assault. The first documented cases of emergency post-coital contraception came in the 1960s with physicians helping victims of sexual assault reduce the risk of pregnancy.[5] As recently as the early 1990s almost one-third of ECP prescriptions were for rape victims.[6] Now, there is growing acceptance in the medical community that emergency contraception should be made available to all women at risk of unintended pregnancy.[7]

The best-known ECP regimen is called the "Yuzpe Regimen" named after Dr. A. Yuzpe, the Canadian physician who first developed the regimen. The Yuzpe regimen consists of two doses of oral contraceptive pills that combine the hormones estrogen and progestin. It has been approved by the drug regulatory agencies of the United Kingdom, Germany, Sweden, Switzerland, USA,

South Africa and New Zealand.[8] Another type of ECP which contains a single progestin hormone – levonorgestrel – is available in the US, Canada and France.[9]

How Emergency Contraception Works?[9,10,11,12]

Emergency Hormonal Contraception

Emergency Hormonal Contraception is just an increased dosage of "regular" oral contraceptives taken in 2 doses. The most common ECPs are "combination pills" that contain estrogen and progestin (synthetic hormones like the ones produced by a woman's body). Women who cannot take estrogen may use progestin-only pills (mini-pills).

ECPs are not effective if the woman is pregnant. They act by delaying or inhibiting ovulation, and/or altering tubal transport of sperm and/or ova, and/or altering the uterine environment (thereby inhibiting implantation). EC prevents pregnancy and helps prevent the need for abortion; it is not a form of abortion.

Emergency Contraception – Intra Uterine Device Insertion

The IUD, used as a regular method of contraception, "alters tubal and uterine transport and affects the sperm and ovum so fertilisation does not occur". Post coital emergency contraceptive insertion of an IUD may involve the same mechanism in some cases, but it may interfere with implantation.

How to Use Emergency Contraception[13]

Emergency Contraceptive Pills

There are several kinds of pills that can be used. The pills are taken in two doses, 12 hours apart. The first dose must be taken within 72 hours of unprotected intercourse. The same type of pill must be used for both doses.

Using Progestin Only Pills

Progestin-only pills appear to be at least as effective for this indication as combined pills and have fewer side effects.

Many common oral contraceptive pills can be used as ECPs, although their manufacturers do not label the pills for this use. "Off-label" use of approved medications is legal and commonplace. A clinician will help to select the dosage and pill that is appropriate for use.

First Dose: Swallow the pills in the first dose no later than 72 hours (three days) after having unprotected intercourse. Nausea is a possible side effect, more common when combination pills are used. It is recommended that biscuits or a glass of milk be taken 30 minutes before each dose to avoid vomiting. A clinician may prescribe an anti-nausea medication or suggest the use of an over-the counter product. The side effects of anti-nausea medication may include sleepiness, lightheadedness and dizziness.

Second Dose: Swallow the second dose 12 hours after taking the first dose.

If vomiting occurs after the first dose, the woman should use an anti-nausea medication 30 minutes before taking the second dose.

If vomiting occurs after the second dose, she should not take any extra pills – it is unlikely that they will reduce the risks of pregnancy any further, but it is likely that they will increase the risk of nausea.

After a woman has taken the pills

- Her next menstrual period may be earlier or later than usual

- Her menstrual flow may be heavier, lighter or more spotty than usual.

- If other health care providers are consulted before getting her period, it is important that she tell them that ECPs have been taken.

- Schedule a follow-up visit with a clinician if menstruation does not begin within 3 weeks or if there are symptoms of pregnancy.

- Be sure to use another method of contraception if sexually active, before menstruation begins again.

Emergency IUD Insertion

Insertion of an IUD can be done by a clinician within 120 hours (five days) of unprotected intercourse.

The Copper T IUD is used for emergency contraception. It can be left in place for up to 3-5 years (depending on strength) to provide effective contraception. Or, if preferred, the IUD can be removed after the next menstrual period, after pregnancy is ruled out.

IUD insertion for EC is not recommended for women who are at risk for sexually transmitted infections:

- Women with more than one sex partner or whose partners have more than one partner
- Women with new partners
- Women who have been raped

Uterine cramps may occur during insertion. Some women feel a bit dizzy. Hence, if a woman has an IUD inserted, she may want to have someone with her to escort or drive her home. She should plan to rest at the clinic until she is comfortable.

The side effects, advantages, and disadvantages of using IUDs for EC are the same as those associated with using IUDs for ongoing contraception.

Who Uses Emergency Contraception?

Millions of women around the world have used EC safely and effectively.[9,15] ECPs are less effective than the more popular pre-coital methods of contraception, and in general practice, women only turn to EC in emergencies – as a back up to their usual birth control method. In a recent study described in the New England Journal of Medicine, women who were given ECPs to take home used other birth control methods at the same rate as women who didn't have the pills at home. Women who had the pills at home were more likely to use EC once and they were not likely to use it repeatedly. Women who had home access to ECPs used the method correctly 98 percent of the time and had fewer unintended pregnancies.[15]

Side Effects and Complications

Yuzpe Regimen ECPs: Combination hormone ECPs induce nausea in 30-50 percent of women, and vomiting in 15-25 percent of women. Antiemetic medications taken one hour before the ECPs may reduce these side effects. Breast tenderness, irregular bleeding, and headaches may also occur. These side effects usually taper off one or two days after the second ECP dose has been ingested.[10, 16]

Progestin-only ECPs: Nausea and vomiting are far less common when using Progestin-only ECPs than when using the Yuzpe regimen.

In the recent WHO supported study of levonorgestrel, nausea occurred in 23.1 percent of cases and vomiting in 5.6 percent. Other side effects were also less common.[17]

IUDs: Side effects of IUD insertion may include abdominal discomfort, vaginal bleeding or spotting and infection. Possible side effects of IUD use include heavy menstrual flow, cramping, and rarely, infection, infertility, or uterine puncture.

Menstrual Changes: In about 10-15 percent of women, ECPs change the amount, duration, and timing of the next menstrual period. This effect is usually minor, and menstruation occurs a few days earlier or later than expected. If ECPs are used frequently, periods may become irregular and unpredictable.[16]

Pregnancy: After using EC, women should discuss any signs of pregnancy with their clinicians. The signs include; a missed menstrual period, nausea, inexplicable fatigue, sore or enlarged breasts, headaches, and frequent urination.[19]

EC may not prevent ectopic pregnancy – pregnancies that develop outside the uterus. Ectopic pregnancies, left untreated, will cause complications that can cause death. Women should seek medical attention if they have signs of ectopic pregnancy, which include – severe pain in the lower abdomen; abdominal pain and spotting, especially after a very light or missed menstrual period; and feeling faint or dizzy.

Sexually Transmitted Infections, Including HIV

Neither ECPs nor IUDs prevent the spread of sexually transmitted infections (STIs), including HIV. Many women who need EC are at risk of these infections. At heightened risk are those who have had unprotected sex in a non-monogamous relationship or with a new partner, those who use intravenous drugs or have a partner who does; and are victims of sexual assault. For those who are at risk of STIs, ECPs are likely to be safer choice than IUD insertion. During IUD insertion, bacteria from a pre-existing infection can be introduced into the sterile uterine cavity, leading to pelvic inflammatory disease (PID).

HIV infection can also increase the risk of pelvic inflammatory disease associated with an IUD.[18]

Who Can Safely Use Emergency Contraception[13]

Almost every woman who needs EC can safely use ECPs – even women with contraindications to the ongoing use of oral contraceptives may use them. ECPs should not be used by women who are already pregnant, not because the pills are thought to be harmful, but because they won't work. A woman should not use an IUD if she is pregnant, has a sexually transmitted infection such as Chlamydia or Gonorrhea, has a history of PID that has impaired her fertility, or other conditions that affect her reproductive system.

Currently there is no reason to believe that ECPs will harm a foetus. Nevertheless, it is advised that a woman should not use EC if she is pregnant.

Efficacy of Emergency Contraception [5,13,14]

Emergency Hormonal Contraception

Not every woman at risk of pregnancy actually becomes pregnant. On average, only eight of 100 women will become pregnant after having unprotected sex during the second or third week of their menstrual cycles. But if they take combined (Yuzpe regimen) ECPs only two out of those 100 women will become pregnant. ECPs thus reduce the risk of pregnancy by roughly 75 percent, preventing six of eight likely pregnancies.

Progestin-only ECPs were found to reduce the risk of pregnancy by 85 percent in a World Health Organisation supported study involving almost 2000 women in 21 clinics around the world.

Two time factors influence the efficacy of ECPs – the amount of time elapsed since unprotected intercourse, and the time in a woman's cycle at which she had sex. The earlier ECPs are taken after unprotected intercourse, the more effective they are. The closer a women is to ovulation (i.e. the higher her risk of pregnancy) at the time of unprotected intercourse, the less likely the method will succeed.

ECPs do not continue to prevent pregnancy during the rest of the cycle, after use. Other methods of birth control must be used.

Emergency IUD Insertion

The risk of pregnancy is reduced by 99.9 percent. Only one out of 1,000 women will become pregnant after emergency IUD insertion.

HOW DO ECPs AND THE IUDs COMPARE? [14]

	ECP	IUD
Efficacy	High	Very High
Use up to	12 hours	5 hours
Contraindications	Virtually none	Few
Method provides contraceptive cover for rest of the cycle	No (Condoms may be used)	Yes (and long term if appropriate)
Requires medical intervention (Procedure examination)	Not always	Always
Suitable for multiple exposures	No data on efficacy	Suitable, as long as it is inserted within five days of unprotected intercourse
Breastfeeding (lactational amenorrhoea, fully up to 6 months postpartum confers substantial contraceptive cover)	Not contraindicated	Not contraindicated

The Difference Between Emergency Contraception and Medical Abortion [13]

Frequently Asked Questions

Q. Isn't emergency contraception the same as abortion?

A. No. Emergency contraception is just that – contraception. By preventing pregnancy, EC actually reduces the need for abortion.

EC prevents pregnancy, which the medical community defines as beginning when the fertilised egg is implanted in the uterus. Although researchers are not yet certain exactly how EC works, they believe that it may prevent fertilisation by inhibiting or delaying ovulation or changing the way the sperm moves in the fallopian tubes. It may also interfere with implantation by changing the lining of the uterus – making it inhospitable for implantation.

Q. Isn't emergency contraception – the "morning after pill" – the same as RU 486?

A. No. The medication used for EC and the drug mifepristone (RU 486) are not the same. Mifepristone is used as a method of early medical abortion that can be used many weeks after implantation when pregnancy begins. There have been test trials in the US, and the FDA has declared mifepristone safe and effective for use in early medical abortion. Mifepristone also shows promise for a range of other medical uses, including EC. Nevertheless, the emergency contraception medicines used today should not be confused with mifepristone.

IMPORTANT

Emergency contraception is meant for emergencies only. It is not as effective as the regular use of reversible contraception, for example: the injectable contraceptive, the IUD, or the Pill.

Emergency contraception offers no protection against sexually transmitted infections. Testing for sexually transmitted infections should be considered if there is a possibility of exposure during unprotected intercourse.

Breaking the Silence About EC in India [20]

The Population Council hosted a first ever workshop on EC in India. The workshop was to:

- share experiences related to EC in developing and developed countries:

- identify a possible niche for EC in the reproductive health landscape in India.

Fifty-three participants attended the workshop, representing India and seven other countries (Nepal, Bangladesh, Kenya, Vietnam, Pakistan, the United Kingdom and the United States of America). Participants also represented diverse constituencies, ranging from grass roots women's health advocates, to non-government organisations to academic and practicing physicians, to media and policy makers.

The workshop was designed so that the participants receive a complete background about the concept, an overview of the experiences with the method in other countries and a review of the current status in India. The discussion focused on the need for EC not just as another method but also its place within the larger reproductive health agenda by highlighting the context of sex and sexuality in the region. This enabled not only an analysis and discussion on the needs and concerns of service providers, women's health groups, policy makers and planners but also helped participants to chart a course for future research, an assessment of current readiness for EC and to create policy recommendations.

At the end of the workshop, government representatives spoke of developing an EC training protocol and since then have had several training workshops. In fact, the then Family Welfare Secretary made a commitment in one of the national dailies to train all medical officers in the primary health centres. The media and non-government organisations spoke of demystifying clinical knowledge and supporting information campaigns. The media representatives also responded by writing several responsible articles in leading newspapers and magazines on the subject. The two and a half day workshop ended on a positive note brought about by sharing of information and experience and ensuring that the process towards the introduction of EC in India had begun with consensus.

Some sections of the fact sheet have been adapted from the Emergency Contraception Handbook by Planned Parenthood, Federation of America Inc.

Guidelines for Service Providers

Indications for EC[21]

Unprotected Intercourse

- Not using any contraceptive method.
- Coitus interruptus/failed coitus interruptus.
- Ejaculation on external genitalia.
- Miscalculation of the rhythm method (fertility awareness method/ period abstinence.)
- Condom rupture, dislodgment or misuse
- Diaphragm/cap inserted incorrectly, dislodged during intercourse, found to be torn or removed too early
- Complete or partial expulsion of an IUD
- Mid-cycle IUD removal considered absolutely necessary
- Spermicide used alone in women at high risk of pregnancy
- Missed combined pills: EC is empirically indicated if more than two pills are missed or where there is a high level of anxiety. Actually, if a woman has taken the first seven pills, and then misses pills for seven days and has unprotected sex, contraceptive protection is lost.
- Missed progestin-only pill: if unprotected sex took place at any time between the first missed pills to 48 hours after restarting the pill.
- Sexual assault culmination in rape is an important indication for EC, in such cases the provision of emergency contraception should not be affected by the probability of legal proceedings. Providers must be aware of the possibility of sexually transmitted infections. The question of police involvement so that forensic tests may be conducted should also be raised. Any woman who has experienced sexual assault will also require long-term emotional support.

- Recent use of suspected teratogens:
  a). drugs, e.g.: cytotoxic

  b). live vaccines such as yellow fever

Emergency Hormonal Contraception

The most widely used preparation is the combined estrogen-progestin regimen, also called the Yuzpe method, which has been approved by the Committee on Safety of Medicines (CSM).

Combined Emergency Contraceptive Pills

- It can consist of 200 mcg of ethinyl-estradiol and 1 mg of levonorgestrel (4 tablets of Ovral G or 8 tablets of a low-dose contraceptive like Mala-D). Treatment should begin within 72 hours of unprotected sex. Half the treatment (100 mcg of ethinyl-estradiol and 500 mcg levonorgestrel) should be taken right away. The other half is taken 12 hours later.

Dosage: Two tablets of a regular contraceptive like Ovral G or 4 tablets of a low dose contraceptive like Mala-D should be taken as soon as possible after unprotected sex and not later than 72 hours. This must be repeated 12 hours later. Whenever possible, it is preferable that the first dose is taken as soon as possible after obtaining the tablets. However,
it is important that the first dose is taken at a time that enables the woman to take her second dose conveniently, during normal waking hours.

- If emergency hormonal contraception is required for a patient on liver enzyme inducing drugs, such as Rifampicin (commonly used for tuberculosis), it is suggested that three tablets are taken first, with another three tablets taken 12 hours later (total dose six tablets).

- Antibiotics can be taken concurrently with ECPs.

Management of a Request for EC [22]

History – Ask About:

- Date of LMP – was it normal

- Length of the woman's normal menstrual cycle

- The timing of all acts of inadequately protected intercourse, in relation to the current cycle [which cycle day or days?]. From the

above, you can work out the risk of pregnancy (usually 20-30 percent in mid-cycle).

- Number of hours since the first episode of unprotected intercourse. If < 72 hours you can choose ECPs or the IUD, if >72 hours and up to 96 hours the IUD is the recommended option (see 'Fact Sheet" section on Emergency IUD on page 7 for details)

- Current/recent use of contraception (to help in planning future ongoing contraception)

- Medical history relevant to EC and to the chosen method of ongoing contraception:
  - history of recent sexually transmitted diseases/infections

Examination

- Check blood pressure as is the practice in a routine contraceptive consultation

- Perform a pelvic examination if:
  - you suspect a pregnancy (a pregnancy test should also be conducted), for pelvic infection

  - the patient requests an examination because of previous gynaecological pathology or opportunistic cervical screening.

- Explain the two methods of EC, their risks, failure rates and the importance of follow up. Advise that the next period may be early or late. Stress that EC is not intended to bring on a period.

- Explore the patient's attitude to possible failure of the regimen and consequences of pregnancy. Inform the patient that, to date, there has been no evidence that hormones used after intercourse carry a risk of teratogenicity. However, a normal outcome to <u>any</u> pregnancy cannot be guaranteed.

- After the discussion, record the woman's decision to use EC and provide an information leaflet, if available.

The practice of abstinence or careful use of the barrier method until the onset of the next period should be advised, unless the emergency IUD is the chosen method. If the woman is taking oral contraceptives,

she should continue with her current packet and use extra precautions for seven days (barrier method or abstention).

Future contraception must be discussed in a sympathetic way and preferably, arranged as appropriate. If the woman wishes to use the combined pill or the progestin-only pill, it can be started on the first day of the subsequent period. The patient must be advised to seek immediate help if the period is significantly different than usual, especially if it is exceptionally light indicating failed treatment or ectopic pregnancy. If the day 5-start option is chosen, extra contraceptive precautions should be used for seven days.

An accurate record written at the time, dated and signed by the provider, is essential, especially in relation to the patients' attitude to a possible failure of the regimen.

Information Provision for EC [22]

Educate all contraceptive users, especially those using barrier methods, about the availability of EC. Make use of posters and leaflets to increase awareness. Emphasise that EC is effective up to 72 hours after unprotected intercourse in the case of the hormonal method, and up to 120 hours in the case of the IUD.

Follow-up

The woman should be strongly advised to follow-up within 3-4 weeks of her treatment or if she has not had a period, has lower abdominal pain, heavy bleeding or is concerned and worried. If it is not practical to offer a designated follow-up appointment, the woman should be advised to contact a family planning service provider if she experiences pain, abnormal bleeding or her subsequent period is unusually light, heavy, short or absent. At the follow-up, details of the post-treatment menstrual period should be recorded. It is important to ensure that:

- *The treatment was successful.* If pregnancy is suspected, a pelvic examination is recommended and a pregnancy test may sometimes be necessary. If pregnancy is diagnosed, it should be managed as for any other unintended pregnancy.

- *The woman is using an effective method of contraception.* Women fitted with an IUD may wish to retain the device but should feel free to ask for its removal if another method is preferred.

HOW SOON CAN REGULAR CONTRACEPTION BE INITIATED AFTER USING HORMONAL METHOD OF EC [21]

Method	When to Initiate
Condom	Can be used immediately.
Diaphragm	Can be used immediately.
Spermicide	Can be used immediately.
Oral Contraceptive (OC)	Initiate a new pack, either according to manufacturer's instructions after beginning the next menstrual cycle, or begin taking one OC tablet daily the day after ECP treatment is completed. Women using Ovral L, Mala-D or Novelon for emergency contraception can continue taking one pill per day from the same pack.
Injectables	Initiate within 7 days of beginning the next menstrual period.
Intrauterine Device (IUD)	Initiate during the next menstrual period (if the patient intends to use an IUD for ongoing contraception, consider inserting a copper-releasing IUD for emergency contraception rather than using ECPs).
Fertility Awareness (safe period)	Initiate after onset of the next normal menstrual period and after the patient has been trained in using the method.
Sterilisation	Perform the operation any time after beginning the next menstrual period.

Guidelines for Users[14, 22]

Did it Happen to You?

- You didn't use any method of birth control
- A condom broke or slipped off
- You had sex when you didn't expect to
- You stopped taking birth control pills for more than a week
- You missed as many as half your birth control pills in the past 2 weeks
- You were forced to have sex and you don't wish to get pregnant.

You Have an Option Called Emergency Contraception (EC)

Emergency contraception is available in two commonly used methods consisting of two doses of hormone pills (ECPs) or the intrauterine device (IUD) insertion. The first dose of pills is taken as soon as possible after unprotected intercourse. The hormones are estrogen and progestin, which are present in regular birth control pills. ECPs provide a sudden high level of hormones. This interferes with the hormone patterns essential for pregnancy to start. The egg release from the ovary is prevented or delayed and the development of the uterine lining is disturbed. This action makes it difficult to get pregnant. However, these disruptions are temporary, lasting only a few days.

The IUD commonly called Copper-T, can be inserted. It prevents fertilisation and interferes with the implantation of fertilised eggs,

Timing is Everything!

EC must be taken as soon as possible – no later then 72 hours after unprotected sex, in the case of the pill and not later than 120 hours (5 days) after unprotected sex in the case of the IUD Copper-T.

If you have had one act of unprotected sex since your last normal period, and it was not more than 72 hours ago – ECPs make sense, if it was more than 72 hours and less than 120 hours ago – then the IUD makes sense.

But if you have had unprotected sex more than once and at least one of these times was more than 72 hours ago, you may already be pregnant. If you are already pregnant then ECPs/IUDs will not work.

Talk to your doctor before using ECPs/IUDs, if you think you might have become pregnant last month.

Temporary Side Effects

ECPs: About one third of women experience nausea or vomiting. Less common temporary side effects are headaches, breast tenderness, dizziness and fluid retention. Many studies on ECPs have demonstrated that they work well. No serious health problems have been reported.

IUDs: Some abdominal pain with spotting or a little bleeding has been observed in some women after the IUD insertion. Usually it settles down in a few days. If the bleeding is heavy or the pain severe, you should see a doctor.

Effectiveness

ECPs prevent pregnancy in more than 75% cases. The IUD prevents pregnancy in 99% cases.

Caution

- ECPs/IUDs do not prevent sexually transmitted diseases including HIV/AIDS.

- ECPs/IUDs do not cause an abortion, if already pregnant.

- ECPs/IUDs may not prevent ectopic pregnancy (pregnancy in the tube or anywhere other than the uterus), and ectopic pregnancy is an emergency.

- When ECPs are used repeatedly, the risk of pregnancy is higher than the failure risk of established regular contraceptives.

- If your period does not start 3 weeks after using EC or is heavy, scanty or painful, see a doctor.

- EC is a back-up method and not a replacement for regular contraception.

Guidelines for Policy Makers[3,23,24,25,26]

The Need for Emergency Contraception (EC):
In terms of:
Consequences of unintended pregnancy such as:

- Abortion
- Miscarriage
- Birth

Emergency contraceptives are potentially life saving. Reducing pregnancy related morbidity and mortality would also lead to increased productivity.

Economic and social conditions such as:
- Low status of women in society which leads to sexual coercion within marriage
- Lower coital frequency in cases of partner migration and polygamy
- Social upheavals which lead to warfare and the use of rape as a weapon for political intimidation
- Prostitution associated with poverty

Age structure:
- Early initiation of sexual activity in young couples before practicing contraception
- Providing EC services can be a bridge to contraceptive information and can represent the critical first encounter with the reproductive health care provider

Cost:
Post coital contraception is a cost effective means of preventing unwanted pregnancies. The savings to the health system of averting

an unwanted pregnancy or unsafe abortion more than cover the cost of EC supplies and services. In most settings, the more expensive part of expanding access to EC is informing users and providers about the option.

Barriers to the Use of EC

- Lack of information on the part of both women and health care providers is a significant obstacle to the wider use of EC in both developed and developing countries.

- Because of the short period of time in which EC can work, women need full knowledge of the method before unprotected intercourse occurs, and ready access to its supplies once it does. Few doctors receive training and fewer still discuss the method with clients during routine counselling on reproductive health.

- The lack of public information about EC may be linked to the misconception that emergency contraceptives cause abortion. In fact by reducing the number of unwanted pregnancies, EC can greatly reduce the need for abortion.

In developing countries where many thousands of women experience unwanted pregnancies and an estimated 70,000 to 80,000 women die each year from complications related to clandestine abortions performed in unsafe conditions, EC could save many lives by preventing unplanned pregnancies. While maternal mortality ratios are around 10 deaths per 100,000 live births in Europe and North America, ratios are as high as 270 deaths in Latin America, 420 in Asia and 640 in Africa.[22] India has 4-6 maternal deaths per 1,000 live births of which abortion is responsible for up to one-third of cases.[3]

Objections to EC

Myth: Emergency Contraceptive Pills would encourage people to continue using them as ongoing contraceptives.

Fact: People need emergency contraceptives even though they regularly use contraceptives. The need arises in cases of method failure.

Myth: According to some, the repeated use of ECPs might pose serious health risks.

Fact: An unintended pregnancy poses a health risk that is likely to substantially outweigh any risk from ECPs. Studies have shown that free and easy access to EC does not promote repeated use.

Myth: Emergency contraception is an abortion method.

Fact: Emergency contraception prevents pregnancy by interfering with ovulation or by making the lining unfavorable for implantation. Medically speaking, pregnancy only starts once the fertilised egg gets implanted in the uterus.

Approaches for Providing Access to EC

- By ensuring that all women in the reproductive age group have information on EC and the facilities to obtain it.

- By ensuring that EC methods are readily available and users know where they can be obtained

- By planning mechanisms and resources for providers and programme planners to work with health advocates in order to educate them regarding EC and overcome political or regulatory obstacles to expand access.

- By working out strategies and channels of communication for effective messages to reach programme managers, providers and potential users.[1,22]

Policy Commitments for Action [23]

At the ICPD, governments called for prevention of unwanted pregnancies to reduce the incidence of abortion and for reproductive health, including family planning services that respond to women's needs. Wider access to EC would help meet these goals:

Governments should make it easier for couples and individuals to take responsibility for their own reproductive health by removing unnecessary legal, medical, clinical and regulatory barriers to information and access to family planning services and methods.

Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion.

Lessons for Action

At least 24 countries have explicitly approved EC as a contraceptive measure. Since oral contraceptives are widely used around the world, EC can be used to prevent unwanted pregnancy in almost all settings.

The basic commodities for EC – oral contraceptive pills – are widely available in family planning programmes around the world but are seldom used for emergency purposes because of lack of knowledge or misconceptions. With a modest amount of training, any health care worker qualified to provide oral contraceptives could also provide EC.

Women and communities need to be better informed about emergency contraception so that they can obtain the method during the short period of time when EC can effectively prevent pregnancy.

"Emergency contraception has an important part to play in helping women achieve their reproductive intentions by avoiding unwanted pregnancies. The provision of these methods through official family planning programmes and/or through alternative services, where this is not already the case, should be considered as part of the long-term strategy to improve reproductive health care." [23]

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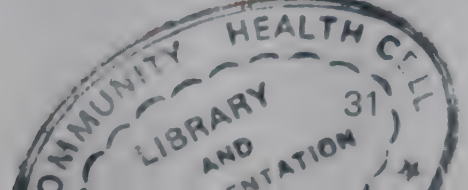

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